

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026427

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6520

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED JUN 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>St Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>1325 CARR.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jimmie</u> Middle <u>Stewart</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>63</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1905</u> 9. AGE (last birthday) <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (City and state or country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>2-9698-LEONA BROWN 807 Clara</u>	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CHRONIC PYELONEPHRITIS</u> DUE TO (c) <u>6000</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>COR PULMONALE, PULMONARY CONGESTION</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>2:05 p.m.</u> Month, Day, Year <u>6-9-63</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6-9-63</u> to <u>6-17-63</u> and last saw him alive on <u>6-17-63</u> Death occurred at <u>2:05 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. E. Cozart MD</u> (Degree or title)		22b. ADDRESS <u>1515 Larayette Avenue</u>	
22c. DATE SIGNED <u>6-17-63</u>		22d. LOCATION (City, town, or county) <u>Le May</u> (State) <u>MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>6-22-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Dale</u>		23d. LOCATION (City, town, or county) <u>Le May</u>	
24. FUNERAL DIRECTOR <u>PRICE UND. CO 2829 Washington</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 21 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Reed Smith. M.D.</u>		27. DATE SIGNED <u>JUN 21 1963</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

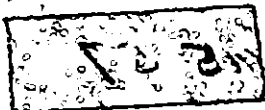
DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

COZART



### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Edward A. Flynn*

Licensed Embalmer No.

*4444*

P. O. Address

*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.